State of New Jersey
Department of Labor
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

WC-171 (R-5-02)

RESPONDENT'S ANSWER TO DEPENDENCY CLAIM PETITION

CASE No. _____

D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

VS

RESPONDENT

NAME

ADDRESS (including County)

ATTORNEY FOR RESPONDENT

❑ NEW JERSEY REGISTRATION NUMBER ❑ SSN ❑ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

INSURANCE CARRIER

NAME (indicate if Not Covered or self-insured)
NJ Reg. or FEIN

ADDRESS

CARRIER'S CLAIM FILE NUMBER

IN ANSWER TO THE DEPENDENCY CLAIM PETITION FILED IN THIS CAUSE RESPONDENT STATES:

DECEDENT

SOCIAL SECURITY NUMBER	ADDRESS (Including County)
NAME	

Date Injury Occurred	Date Employer Had Knowledge of Injury	Date Injury Reported	Date Stopped Work	Date Returned to Work	Date of Death

How Injury Occurred (If Occupational Disease Give Periods of Exposure)

Where

Nature of Injury

Occupation and Type of Work		Cause of Death	
Medical Expenses $	Burial Expenses $	PAID BY RESPONDENT ❑ Yes ❑ No	
Gross Weekly Wages $	Rate of Compensation $	Compensation Received for Injury $	Total Compensation From Employer $

Employer Furnished Medical Aid	Decedent Gave Written Notice of Article 2 Exemption	Decedent Received Written Notice of Article 2 Exemption
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Respondent agrees with information concerning Dependents named in the Dependency Claim Petition ❑ Yes ❑ No

If no, explain.

Respondent submits the following additional information (Enter none, if appropriate. Use additional sheets, if required).

❑ Demand is hereby made for answers to standard occupational disease interrogatories.

❑ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies.

I certify that the foregoing statements are true to the best of my knowledge, information and belief.

_____ _____

Attorney for Respondent or Respondents Insurance Carrier — Date